PROGRAM GUIDELINES

What is Recuperative Care?

Recuperative Care is a program operated & staffed by Interfaith Community Services that provides emergency housing, meals, case management and medical care to homeless persons who are recovering from an acute illness or injury. The program offers short-term care to individuals with conditions that would be exacerbated by living on the street, in shelters or other unsuitable places. The goal of the program is stabilize the clients’ medical or mental health condition and engage them in managing their ongoing physical and mental health care and housing needs. The program beds are located in Escondido, CA. Although there is nursing coverage, it is not a skilled nursing facility. Please review the attached admission criteria before submitting a referral.

Referral Process:

A hospital social worker, discharge planner, or case manager may call to initiate a referral and check on bed availability. Patients may not self-refer.

To inquire about bed availability, contact the Recuperative Care Intake Coordinator, Joan Rector, RN at (760) 294-2025 Ext. 117/ cell (760) 877-1729 or Erica Cowell at Ext. 115. To make a referral, complete and fax the referral form to the Recuperative Care Program office at (760) 294-6056. Referrals will be reviewed Monday through Friday 08:00am to 5:00pm. Client referrals for same-day placements must be received by 11:00 a.m. The Intake Coordinator will review the referral and notify the hospital contact of a preliminary approval or denial. If the referral is preliminarily approved, the Intake Coordinator will assess the referral in the hospital and provide a final decision regarding acceptance into the program.

Admit Process:

The hospital is responsible for arranging transportation for the client to the Recuperative Care facility located at 250 N. Ash St., Escondido, CA 92027. Clients must arrive by 4:30 PM Monday – Friday to be admitted. Other arrangements must be approved by the Recuperative Care Program Manager.

Before the client is discharged from the hospital, the client needs to be provided with medication for 30 days and any necessary assistive devices.
PROGRAM CRITERIA

Admission Criteria: (Client must meet all)
- Adult (18 years of age or older) and homeless
- Acute medical or psychiatric problem requiring short-term respite care with an identifiable end point of care for discharge
- Medically and behaviorally stable (not a risk to self/others, appropriate for group setting)
- Independent in mobility, transfer, feeding, dressing, and not known to be fall-risk
- Independent in Activities of Daily Living
- Able to independently administer medications
- Agreeable to admission and receiving care from Recuperative Care staff
- Be willing to comply with medical recommendations and treatment plan goals
- Agree to abstain from drugs and alcohol while in Recuperative Care program
- Bladder and bowel continent
- Have scheduled subspecialty follow-up appointments as indicated

Acceptable Conditions:
- Wheelchair or walker use
- Bowel prep, pre-surgical procedures
- Chemotherapy – administered via hospital outpatient clinic
- CPAP use
- IV infusion - QD or BID orders (PICC lines must be in place at admission)
- Insulin dependent diabetic
- Wound care – up to BID dressing change
- Wound VAC, if small and attached
- Portable oxygen use

Exclusion Criteria:
- Fecal and/or urinary incontinence without management plan
- Registered sex offenders
- Unstable medical or psychiatric conditions that require an inpatient level of care
- Dangerous to self or others; unable to live in a group environment
- IV hydration (Individuals requiring IV antibiotics must be able to self-administer or the hospital must arrange a Home Health Nurse come to the Recuperative Care housing)
- Contagious air-borne respiratory illness
- Active substance users who are unable or unwilling to abstain while in program
# REFERRAL CHECKLIST

## Forms/Medical Records
- ☐ Program Referral Form
- ☐ Program Release of Information
- ☐ Verification of Homelessness
- ☐ Medication List
- ☐ Initial History and Physical Evaluation
- ☐ MD progress notes detailing hospital course/updated medical condition
- ☐ Specialty Consult Notes (orthopedics, cardiac, psychiatry, etc. if applicable)
- ☐ MD Discharge Summary with plan (follow-up appts must be noted)
- ☐ PT/OT Clearance if patient requires assistance device of ambulation
- ☐ TB Form/CXR Results
- ☐ Laboratory Studies (blood, imaging studies, cultures, if applicable)

## Upon Discharge
- ☐ 30-day supply of medication (if prescribed upon discharge)
- ☐ Wound care supplies with wound care instructions (if needed)
- ☐ Patient must be discharged with assistive device (if needed)
- ☐ Patient must be discharged with shoes (unless noted that pt did not arrive with any)
- ☐ Patient must have follow-up care plan (specialty follow-up if deemed necessary by provider in charge of pt's care)
# RECUPERATIVE CARE PROGRAM REFERRAL FORM

To refer a client, please complete and fax to (760) 294-6056
Joan Rector, RN (760) 294-2025 Ext 117 or (760) 877-1729
Erica Cowell, MSW (760) 294- 2025 Ext 115

<table>
<thead>
<tr>
<th>Referring Hospital: ___________________</th>
<th>Attending Physician: ___________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Planner/Social Worker: _______</td>
<td>Phone #: ________________________________</td>
</tr>
<tr>
<td>Authorized by: _________________________</td>
<td></td>
</tr>
</tbody>
</table>

## Patient Information

Name: ________________________________  MRN: ________________________________
Date of Birth: _______________________  Referral Date: _______________________
Date Admitted to Hospital: ____________  Anticipated Discharge Date: ____________

Please explain the medical reason for hospital admission: ____________________________________________

Please explain any surgical procedures and/or patient limitations: ____________________________________________

<table>
<thead>
<tr>
<th>Is wound care required? □ Yes □ No</th>
<th>If Yes: ____________________________________________________________________</th>
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</thead>
<tbody>
<tr>
<td>Is Home Health needed? □ Yes □ No</td>
<td>If Yes, please explain: ____________________________________________________________________</td>
</tr>
<tr>
<td>Does the patient have any mental health or substance abuse issues? □ Yes □ No</td>
<td></td>
</tr>
<tr>
<td>Mental Health Diagnosis: ____________________________________________________________________</td>
<td></td>
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<tr>
<td>Substance Abuse: □ Y □ N  Alcohol □  Heroin □  Cocaine □  Painkillers □  Methamphetamines □</td>
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<tr>
<td>Any other medical or behavioral problems? ____________________________________________________________________</td>
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</tbody>
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<thead>
<tr>
<th>Registered Sex Offender?: □ Yes □ No</th>
<th>Outstanding Warrants?: □ Yes □ No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires Oxygen □ Y □ N  Self-Administer Meds? □ Y □ N</td>
<td>If No: □ Needs reminders □ Needs assistance</td>
</tr>
<tr>
<td>Continent of Bowel/Bladder? □ Y □ N</td>
<td>Requires IV Antibiotic? □ Y □ N  Communicable Disease? □ Y □ N</td>
</tr>
<tr>
<td>Ambulatory? □ Y □ N  Assistive Device? □ Y □ N</td>
<td>If Yes: □ Walker □ Cane □ Wheelchair □ Crutches</td>
</tr>
<tr>
<td>Blood Work (Coumadin)? □ Y □ N  Diabetic? □ Y □ N</td>
<td>If Yes: Requires Insulin □ Y □ N</td>
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</tbody>
</table>

Estimated length of stay in recuperative care program: _______ days  □ Medications List (please fax)

## For ICS RCP STAFF USE ONLY

<table>
<thead>
<tr>
<th>Approved? □ Yes □ No</th>
<th>If denied, reason: ____________________________________________________________________</th>
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<tbody>
<tr>
<td>Reviewed by: ___________________</td>
<td>Date: ___________________  Time: ___________________</td>
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<tr>
<td>Admission Date: ____________  Time: ____________  House #: ___________________</td>
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</tr>
<tr>
<td>Discharge Date: ____________  Time: ____________  Discharge Summary: □ Yes □ No</td>
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<tr>
<td>Notes: ______________________</td>
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Release of Confidential Information

I, ___________________________  MRN ___________________________  Date of birth: ___________________________
authorize the staff of Interfaith Community Services to obtain information from and/or give information to:

Name/Organization: ____________________________________________
Address: ______________________________________________________
Phone: _________________________________________________________

Disclosure of this information is for the following purpose:

Referral and coordination of care for Interfaith Recuperative Care Program

Please check type of information authorized:

<table>
<thead>
<tr>
<th>Medical treatment</th>
<th>Psychiatric evaluation</th>
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<tbody>
<tr>
<td></td>
<td>x</td>
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<table>
<thead>
<tr>
<th>Alcohol/Drug treatment</th>
<th>Biopsychosocial assessment</th>
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<tr>
<td>x</td>
<td>x</td>
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<table>
<thead>
<tr>
<th>Educational records</th>
<th>Progress notes</th>
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<tr>
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<table>
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<tr>
<th>Employment/Vocational assessment</th>
<th>Discharge summary</th>
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</table>

Other: Medical/psychiatric appointments, income, disability, housing status  x

I understand that my drug and/or alcohol treatment records are protected under Federal regulations governing Substance Abuse Patient Records (42 CFR, Part 2) and HIPAA (45CFR, Parts 160 & 162) and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that the information in my records authorized for disclosure may include information about sexually transmitted diseases, HIV, and AIDS; it may also include information about mental health treatment and services. I understand the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer be protected by the HIPAA regulations.

I also understand that I may revoke this consent at any time in writing except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.). This consent expires on _________________ or if not specified, one year after signature or upon termination of the program. I have the right to receive a true copy of this completed form. I understand that a FAXED copy of this authorization may be used as an original.

Client Signature: ___________________________  Date: _______________
VERIFICATION OF HOMELESSNESS

Date: ______________

Institution/Referring Agency: ____________________________________________

To: Interfaith Recuperative Care Program,

☐ Mr. or ☐ Ms. __________________________

Stayed in our:

☐ Hospital
☐ Treatment Recovery Program
☐ Transitional Housing
☐ Other: __________________________

from ________________ to ______________________

Before coming to our program/facility above, he/she had been living:

☐ On the streets
☐ In a car/bus
☐ In a housing program: __________________________
☐ Other inappropriate places (i.e. Parks, abandoned buildings, restrooms etc.)
  Or other places not fit for human habitation

from ________________ to ______________________

Should you have any questions, please do not hesitate to contact me at: ________________________

(Contact #)

Sincerely,

________________________________
(Signature of Referring Institution)
TUBERCULOSIS/COMMUNICABLE DISEASE FORM

All homeless persons are at high risk for TB. Any homeless person with a new cough or change in cough for two weeks or with pulmonary and/or physical symptoms suggestive of TB or pneumonia must have a Chest X-ray (CXR).

Any infiltrate, regardless of lobe or lobes, or any unexplained pleural effusion should be viewed as suspicious for TB. Consequently, any homeless person with the aforementioned respiratory and/or physical symptoms and any sign of an infiltrate on CXR should be considered suspicious for TB until proven otherwise.

These patients will not be admitted to the Interfaith Recuperative Care Program until three AFB smears are negative, or the CXR shows definite signs of clearing on an antibiotic regimen, or the patient demonstrates clear clinical improvement (resolution of fever for at least 24 hours or absence of a productive cough) after 72 hours on antibiotics.

Persons with AIDS are at greater risk for TB, and often the CXR can be negative. Consequently, any homeless patient with AIDS with a productive cough is required to have three negative AFB smears REGARDLESS OF CXR FINDINGS. These patients must be cleared by the Medical Admissions Coordinator prior to admission.

If you have concerns with regard to acceptance of a patient due to PPD status, HIV status, etc, please discuss with the Medical Admissions Coordinator.

I, ________________________________, confirm that the following individual:

(Print Name of Medical Provider)

Client Name: ____________________________________  MRN: __________________________

☐ does*  ☐ does not  exhibit the aforementioned symptoms that are suggestive of TB.

Medical Provider: ________________________________  _____________

(Signature)      (Date)

*(please attach required documentation)

Communicable Disease Disclosure:
We have been witness to a rise in the incidence of numerous communicable diseases over the past few years. In order for our staff to properly care for patients and manage their illnesses effectively we require disclosure of known communicable disease. This is especially true, but not limited to patients who have a history of TB, VRE, and MRSA. We will evaluate each case on an individual basis.